Do Not Staple
Kentucky Employees' Health Plan
Department of Employee Insurance
www.KEHP.KY.GOV ● 1-888-581-8834

2012 KEHP
Active Employee Flexible Spending Account (FSA) Enrollment/Change Application

Insurance Coordinator/HR Generalist Section			
Date of Hire	**Effective Date**	**Org. Unit**	**Company Number**

Reason for Application

- ☐ Rehire
- ☐ New Hire
- ☐ Open Enrollment
- ☐ New Group
- ☐ Qualifying Event (QE) Date: _____
- ☐ Other Reason:

If Qualifying Event, check item below:

- ☐ Divorce/Legal Separation/Annulment*
- ☐ Death of a Child or Spouse*
- ☐ Loss of Eligibility
- ☐ Gaining/Losing other Coverage, Medicare/Medicaid or any Government Group Health Insurance Coverage
- ☐ Gaining/Losing other Coverage
- ☐ Significant Cost Increase or Decrease for Dependent Care FSA
- ☐ Marriage*
- ☐ Birth/Adoption of Child/Placement for Adoption*
- ☐ Guardianship/Court Order*
- ☐ Military Leave/Leave without Pay Date:_____
- ☐ Other Reason*

*Requires Supporting Documentation

_____
Name (Last, First, MI)

_____ _____ _____
Street Address | Home Phone Number | Cell Phone Number

_____ _____ _____
City, State, ZIP | Home Email Address | Work Email Address

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Pers Number **Social Security Number** **Date of Birth**

Healthcare Flexible Spending Account

- ☐ I request to **enroll** in a Healthcare FSA and elect $_____ per pay period.
- ☐ I request to **change** my Healthcare FSA election from $_____ per pay period to $_____ per pay period.

For a total Calendar Year** contribution of $_____.
** Calculate full calendar year amount (1/1-12/31)

Dependent Care Flexible Spending Account

- ☐ I request to **enroll** in a Dependent Care FSA and elect $_____ per pay period.
- ☐ I request to **change** my Dependent Care FSA election from $_____ per pay period to $_____ per pay period.

For a total Calendar Year** contribution of $_____.
** Calculate full calendar year amount (1/1-12/31)

Maximum Contribution per tax filing status: ☐$2,500 married filing separately ☐$5,000 married filing jointly ☐$5,000 single head of household

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Authorization and Certification
I understand and agree that:

- I have made the above plan selection for plan year 2012. I have read and understand the 2012 KEHP Benefits Selection Guide. I understand that plan rules and limitations are contained in the KEHP Summary Plan Descriptions.
- My signature on this application creates a legal and binding contract between the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP), any third-party administrators, Humana and Express Scripts and me.
- All KEHP benefits for me and my eligible dependents will be provided in accordance with the Summary Plan Descriptions and Benefits Selection Guide. I will abide by all terms and conditions governing membership for the Healthcare Flexible Spending Account (FSA) and Dependent Care Flexible Spending Account (DCAP) in which I have enrolled as set forth in the Summary Plan Descriptions.
- The elections indicated on this application may not be changed or cancelled during the Plan Year, without a permitted Qualifying Event.
- Enrollment in an FSA and/or DCAP is voluntary, and I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis.
- I understand that for any claims I seek reimbursement, I (including any dependents) am eligible to seek reimbursement under Code Sections 105(b) and 213(d).
- I understand that an FSA can only reimburse expenses that are incurred during this plan year. I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
- Regarding my FSA, any unused amount remaining in my spending account at the end of the Plan Year cannot be carried forward to the next year due to federal law.
- My Humana*Access*℠ Visa® Card will be suspended if the required FSA claim verification is not sent in to Humana within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the plan concerning the Humana*Access* ℠ Visa® Card. This plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck and offset my FSA if I fail to properly substantiate my FSA claims.
- Pursuant to federal law the cost of over-the-counter medicines (other than doctor prescribed and insulin) may <u>not</u> be reimbursed through an FSA.
- I understand that a DCAP can only reimburse expenses that are incurred during this plan year. I have a 90-day run-out period (until March 31) for reimbursement of eligible HRA expenses incurred during my period of coverage.
- Regarding my DCAP, any unused amount remaining in my spending account at the end of the Plan Year cannot be carried forward to the next year due to federal law.
- Regarding my DCAP, my dependents and I are eligible to seek reimbursement under Code Sections 21 and 129.
- I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to business associates, third party administrators, vendors, consultants, governmental agencies with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Please submit this application to your Insurance Coordinator or HRG

Employee Signature _____ Date _____

Insurance Coordinator/HRG Signature _____ Date _____